

**Initial Refugee Health Assessment Form**

Please submit this form within 30-45 days after its completion to the  
VDH Division of Disease Prevention, Newcomer Health Program  
PO Box 2448, RM 2448, Richmond, VA 23218-2448

Name (Last, First, MI): \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M) US Arrival Date: \_\_\_\_\_

Alien Reg #: A \_\_\_\_\_ File #: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_ TB Status: \_\_\_\_\_

Country of Origin: \_\_\_\_\_ VOLAG: \_\_\_\_\_

Country of Exit: \_\_\_\_\_ Dist. Mailed To: \_\_\_\_\_ Date Mailed: \_\_\_\_\_

**THE HEALTH DISTRICT PROVIDING THE HEALTH ASSESSMENT COMPLETES THIS PORTION OF THE FORM**

**Was the Refugee Located?** (Circle one): Yes No If **Not Located**, provide reason if known: \_\_\_\_\_

If the refugee **was NOT** located, you can not provide as assessment. **Do not continue but return this form to VDH, Newcomer Health Program.**

If the refugee **was located**, provide the name of the **Health District** providing this health assessment: \_\_\_\_\_

Person Completing This Form: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Date of Assessment: \_\_\_\_/\_\_\_\_/\_\_\_\_

**LEVEL 1: REQUIRED MINIMUM, ASSESSMENT FOR TUBERCULOSIS, BASIC HEALTH, LEAD & IMMUNIZATIONS.** (May be completed by PHN, NP, PA, or MD)

(This level is reimbursed at \$500.00 per refugee upon completion of the initial health screening. It includes a one-time reimbursement to the district for all immunizations recommended for the refugee to meet the U.S. Citizenship and Immigration Services Adjustment of Status requirements).

To receive compensation for completing Level I each question requires an appropriate answer.

**Tuberculosis Screening****Mantoux Skin Test Reaction**

- ☐ Negative
- ☐ Positive
- ☐ Given, not read
- ☐ Not done, explain: \_\_\_\_\_

**Chest X-ray (in US) if PPD + &/or S/S**

- ☐ Normal (not TB)
- ☐ Abnormal (TB suspected)
- ☐ N/A (negative PPD & no S/S of TB)

**Therapy (if indicated)**

- ☐ TX for suspected or confirmed TB disease considered
- ☐ Therapy for LTBI indicated
- ☐ Based on evaluation, no therapy indicated now

1. What is the refugee's *primary language* (other than English)? \_\_\_\_\_ (Circle one)

2. Was an interpreter *necessary* to conduct this refugee's health history and assessment? ..... Yes.. No

(If yes, circle the source listed in the box below. If No, skip to Level II)

1. Voluntary Agency Interpreter
2. LHD Trained Staff Interpreter
3. LHD Bilingual Staff
4. Language Line Services
5. Contract Interpreter
6. Other \_\_\_\_\_

**Patient History & General Health Assessment**

- |   | (Circle One) |     |
|---|--------------|-----|
| 1) Review of the refugee's overseas medical record/ pt history .....  | Yes          | No  |
| 2) General mental status assessment (orientation to person, place, time, as age appropriate)? ..... WNL? .....  | Yes          | No  |
| 3) The gross inspection / assessment / systems review. Question for current health problems? ..... WNL? .....   | Yes          | No  |
| 4) A gross evaluation of vision and hearing (eye chart and whisper test)..... WNL? .....  | Yes          | No  |
| 5) A gross dental inspection / assessment (gross inspection of the oral cavity)..... WNL? .....   | Yes          | No  |
| 6) STD follow-up for any STD if identified on federal form DS 2053 or OF-157 .....  | Done         | N/A |
| 7) Is this refugee's weight appropriate for his / her height? .....   | Yes          | No  |
| 8) Is this refugee's hemoglobin & / or hematocrit appropriate for his / her age & sex? .....  | Yes          | No  |
| 9) If 5 years old or over, is this refugee's Blood Pressure grossly within normal limits? (If age <5, circle Yes).....  | Yes          | No  |
| 10) Was blood lead level testing done? (Testing is required for all children 6 years of age or under and recommended for all Refugee children 6-16 years of age within 90 days post arrival in the U.S.)..... | Yes          | No  |

**Immunization Screening**

- 11) Review the refugee's immunization history. Determine if his/her immunization status is current and to date for age. Note: Refugees are required to have certain vaccinations for adjustment of status (done one year post U.S. arrival).

If the refugee is ≤ 18 years of age are immunizations up to date?

If the refugee is ≥ 19 years of age are immunizations up to date?

(Circle One)

Yes No  
Yes No

**LEVEL 2: EXPANDED HEALTH ASSESSMENT (A PHN, NP, PA, or MD may complete this portion)**  
**(Level 2, = \$125.00)**

To receive compensation for completing Level II, each question requires an appropriate answer.

**(Circle one)**

- 1) An assessment *that at a minimum includes listening to heart & lung sounds.*  
 A diagnosis is not necessary, but if sounds are abnormal a referral is necessary.....Done Not Done
- 2) Hepatitis B Screening: (Africa, Asia, Middle East; at times, former Soviet States & Eastern Europe).....Done NA
- 3) Parasite screening: (Africa, Asia, Middle East, and if from a refugee camp) .....Done NA
- 4) **IF FEMALE**, is this refugee currently pregnant? .....Yes No (Male)
- 5) Malaria Screening: (If symptomatic or if from an endemic area).....Done N/A
- 6) Age specific recommended screening:
  - a) **Age <5 years:**
    1. Measure of head circumference ..... WNL? .....Yes No
    2. Assess developmental milestones..... WNL? .....Yes No
  - b) **Age >5-15 years:**
    1. Provide nutritional assessment (if ht & wt <5th %).....Done NA
    2. Assess developmental level / mental status..... WNL? .....Yes No
  - c) **Age >15 years:**
    1. Evaluate further if weight is more than 10% under normal range **OR**  
 If weight is more than 40% over normal range.. .....Done NA
    2. Evaluate for hypertension if BP elevated.....Done NA
    3. CBC, platelets, if hematocrit less than 30% .....Done NA
    4. VDRL if indicated by history or abnormal exam. ....Done NA
    5. Offer HIV testing if indicated by history or abnormal exam.....Done NA
  - d) **Age >46 years or if indicated at any age:**
    1. Stool exam for blood (hemoccult).....Done NA
    2. Fasting glucose .....Done NA
    3. Fasting cholesterol .....Done NA
    4. Cancer information and / or evaluation as appropriate.....Done NA

**PUBLIC HEALTH NURSE CASE MANAGEMENT**

Includes any referrals as necessary based on health assessment. **Make sure the referral corresponds to findings as documented in the previous Levels.**

**(Circle one)**

- 1) Referral for consideration of therapy for TB infection or disease?.....Yes No
- 2) Referral for abnormal vision finding?.....Yes No
- 3) Referral for abnormal hearing finding?.....Yes No
- 4) Referral following a **normal** dental inspection?.....Yes No
- 5) Referral for follow-up due to an **abnormal** dental inspection?.....Yes No
- 6) Referral necessary for an STD/HIV finding?.....Yes No
- 7) Referral necessary for abnormal weight finding?.....Yes No
- 8) Referrals necessary for anemia / malaria findings?.....Yes No
- 9) Referral necessary to update immunizations per ACIP guidelines?.....Yes No
- 10) Referral necessary for Hepatitis B?.....Yes No
- 11) Household contact testing for Hepatitis B necessary?.....Yes No
- 12) Referral required for abnormal parasite screening?.....Yes No
- 13) Referral necessary for developmental delays?.....Yes No
- 14) Referral necessary for mental health evaluation?.....Yes No
- 15) Referral for any other problems identified at health assessment?.....Yes No

This form serves as both an invoice tool and health data collection tool, please complete appropriately and accurately. The program can reimburse Health Districts only. The program cannot reimburse private physicians or non-public health department clinics. However, a health district may choose to contract with a health provider to provide the health assessment. The district then accepts responsibility for reimbursing their contractor.

**PLEASE RETURN THIS FORM TO VDH/NHP AS SOON AS POSSIBLE AFTER THE HEALTH ASSESSMENT IS COMPLETE.**

***Reimbursement Can Only Be Made With Proper Documentation***  
**Forms received one year or more after the refugee's arrival into the U.S.**  
**will be returned; and, the district will not be reimbursed for the services.**

**Questions?**

Contact the Newcomer Health Program @ 804-864-7910  
 Fax Number: (804)864-7913